2011 Military Health System Conference

The Army Comprehensive Behavioral Health System of Care (CBHSOC) Campaign Plan

Standardize to Optimize

The Quadruple Aim: Working Together, Achieving Success

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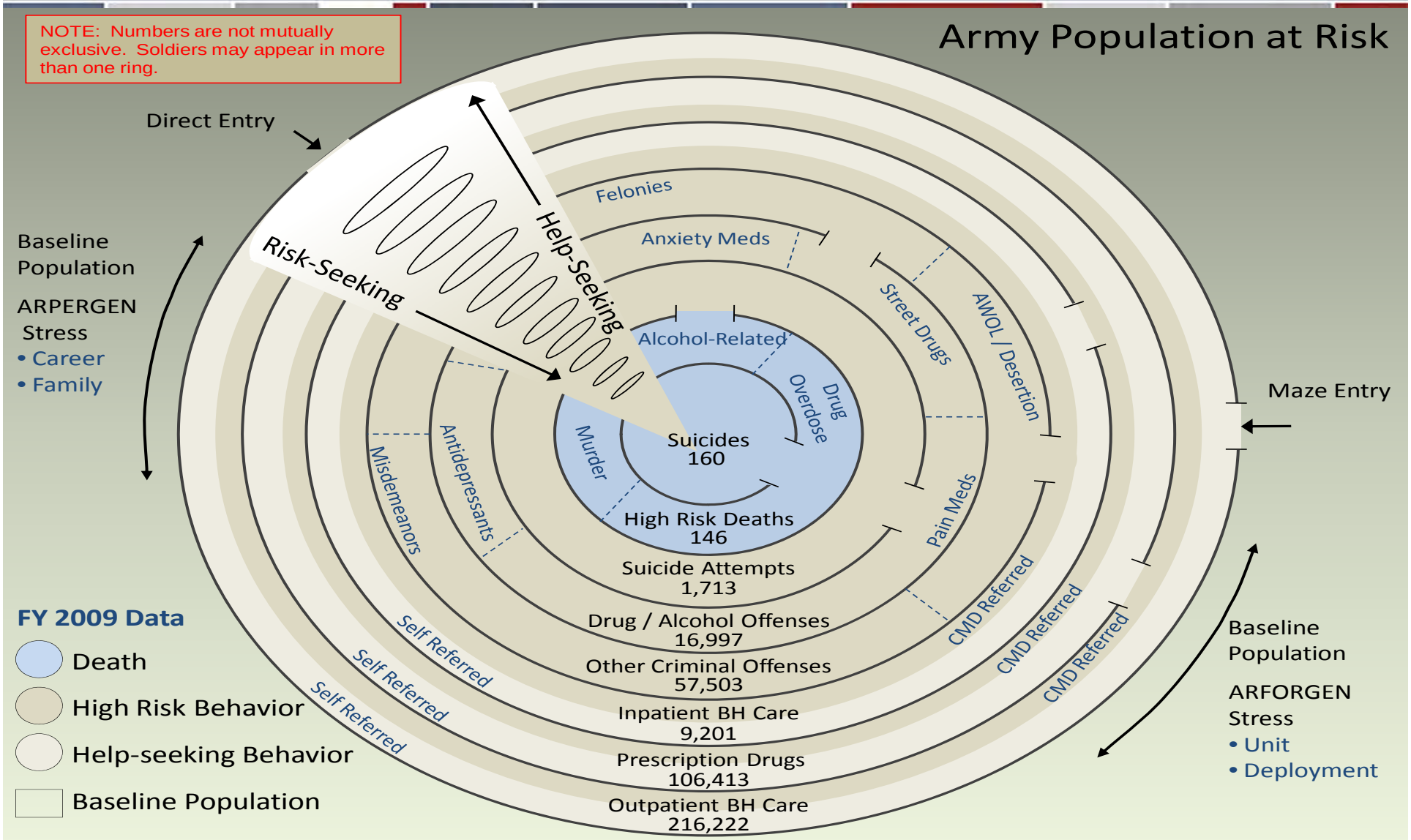
Introduction

- Ongoing conflicts resulted in elevated negative behavioral health outcomes, including deaths by suicide.
- Demand significantly increased for Army Behavioral Health Services.

Increased Demand for Army Behavioral Health

- Two Key Findings from the "*Health Promotion / Risk Reduction / Suicide Prevention Report, 2010*"
  - "While the civilian suicide rate has remained relatively stable through 2007 (with 2008 and 2009 unknown), the Army rate has increased steadily through FY 2009." (p.16)
  - "The greatest increase in military suicides have occurred in the Army and Marine Corps which have borne the greatest burden of ground combat in a protracted war." (p. 16.)

Army Population at Risk



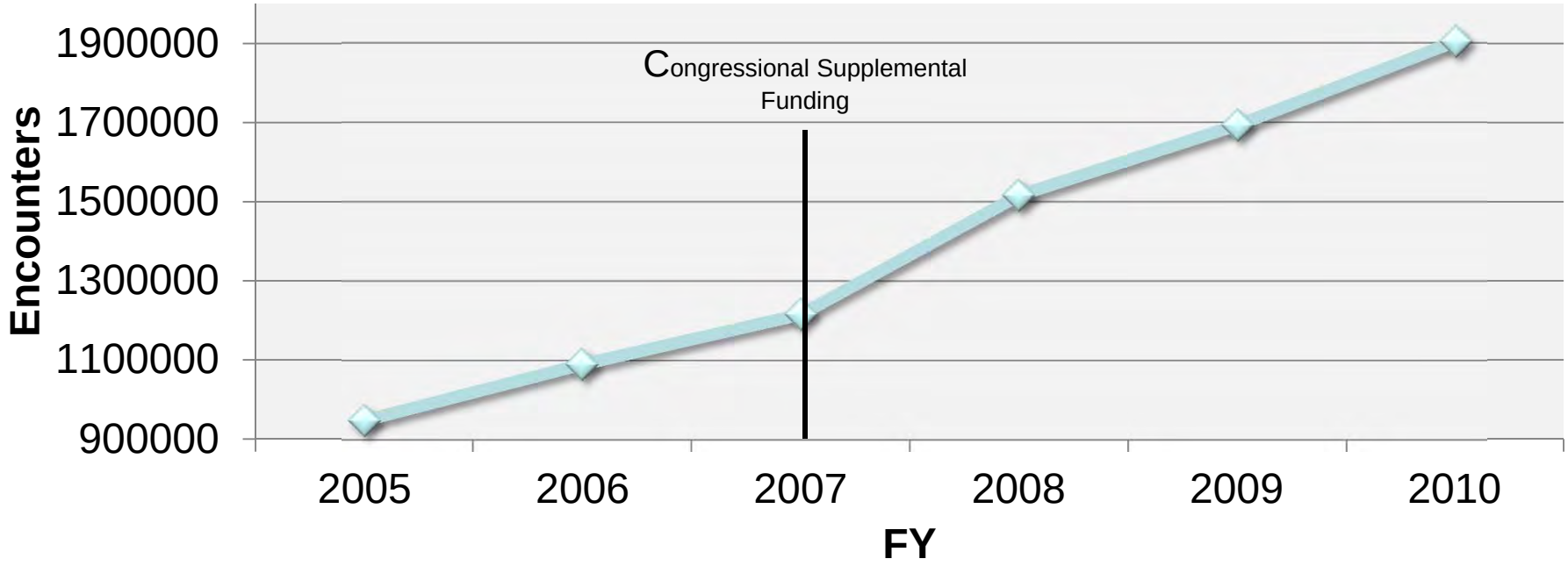
Army Behavioral Health Systems Change

Psychological Health (PH) Spend Plan (2007)

Supplemental funding to improve Behavioral Health Care under the categories of access to care, resiliency, quality of care, and surveillance

Increased Utilization of the Army Behavioral Health System

Behavioral Health Encounters for FY05-FY10



• Patient contacts (encounters) have approximately doubled since FY 2005, with the most significant one year gain in FY 2007.

Army Behavioral Health Systems Change

Comprehensive Behavioral Health System of Care Campaign Plan (CBHSOC-CP) (2010)

A system redesign focused on promoting quality and best practice through standardization and synchronization

CBHSOC-CP
"Standardize to Optimize"

- Vision
  - A nationally-commended, comprehensive, and integrated behavioral health system that fosters optimal physical, emotional and spiritual wellness
- Mission
  - Deliver coordinated care to meet the physical, emotional and spiritual needs of our Soldiers and Families through effective education, prevention, diagnosis, intervention, treatment, documentation and follow-up

Overview of CBHSOC-CP Goals Relative to the Quadruple Aim

- Readiness
  - Increased Resiliency
  - Optimal operational mission capability
- Population Health
  - Reduced Symptoms, Stress and Lost Work Days
  - Improved Functioning
- Experience of Care
  - Better Access, Continuity of Care and Satisfaction
- Per Capita Cost
  - Reduced overall severity and disability

Assumptions of CBHSOC-CP

- By doctrine and best practice – quality BH care is delivered:
  - Proactively/Preventively
  - Far forward - closest to the recipient
- Requires standardization of:
  - BH data (clinical and non-clinical)
  - Clinical processes and instruments
  - Outcome metrics-Evaluation methods
- Data Driven Care

CBHSOC-CP Work Groups: Framework and Priorities

- Work Groups (WGs) identify needs, ways and means to operationalize and institutionalize CBHSOC-CP tasks
- 14 WGs total (including critical and supportive)
- All parts of the CBHSOC-CP effort require:
  - Development of standardized screening instruments across Army Force Generation
  - Standardization of enterprise-wide BH data system
  - Tele-BH system support (scheduling & connectivity across Regional Medical Commands)

CBHSOC-CP Work Groups: Framework and Priorities cont'd

- Continuous program evaluation using standardized "metrics" to:
  - Chart progress in 3 major domains – outcomes/compliance/resourcing
  - Identify & implement evidence-based best practices
  - Identify & eliminate redundancy
  - Inform MEDCOM leadership of clinical programs meriting proliferation consideration enterprise-wide
- Reserve Component's full program integration
- Synchronization with parallel efforts
- STRATCOM

Conclusion

- Increased resourcing (PH Spend Plan) and the CBHSOC-CP are the Army's response to the increased demand for, and the long term sustainment of, behavioral health services.
- Key to success will be to standardize existing systems around validated initiatives utilizing outcomes as the basis of sustainment.
- Current system enhancements are envisioned to be an enduring requirement that will exceed current operations.

Status of CBHSOC-CP to Date

Back Up

Status of CBHSOC-CP to Date

- HQDA EXORD published (EXORD 277-10)
  - Mandates screening points and use of Down Range Assessment Tool
  - Directs Army-wide support to MEDCOM implementation
- MEDCOM CBHSOC Campaign Plan OPORD published (OPORD 10-70)
  - FRAGO 1 provides coordination requirements for transfer of BH care during PCS
  - Additional FRAGOs to be published as required going forward

Status of CBHSOC-CP to Date cont'd

- Standardized deliverables – constantly updated, tracked & stored on SharePoint website
- BH data system (ABHC prototype) received DBT certification 9 DEC 2010
- MEDCOM CBHSOC Campaign Plan Governance
  - Key stakeholder collaboration in campaign development and execution: VCSA, G1, G6, CSF, OCCH, ASA M&RA, OCAR, and NGB
  - General Officer Steering Committee
  - Council of Colonels

ARFORGEN Cycle Screening

TOUCH POINT #1

Pre-deployment Health Assessment: *Screening 1- 120-60 days pre-deployment screening and intervention for deployability and risk assessment. Screening 2- 2 months before estimated date of deployment.*

- **Screener:** Primary Care, given at SRP, provider reviewed and referrals given when indicated. NDAA 2010 requires face to face provider screening.
- **Enablers:** Automated Behavioral Health Clinic (ABHC), Virtual Behavioral Health (VBH), Face to Face
- **Mode:** DD FORM 2795
- **Outcome:** Risks are identified in advance and mitigated to retain Soldier for deployment. Stratifies Risk.
- **Target:** Medical and behavioral health for Soldiers.
- **Proposed:** Medical and behavioral health for Family.

TOUCH POINT #2

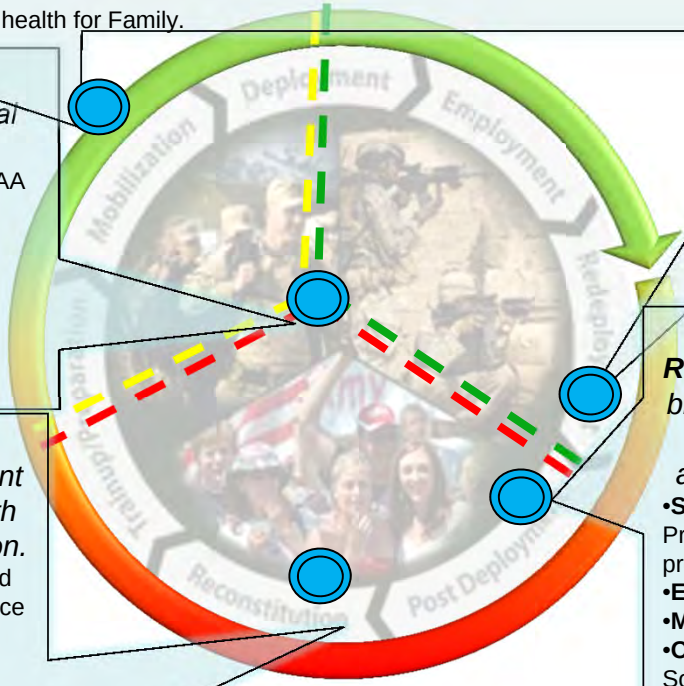
In-theater prior to re-deployment: *15-90 days screening for risk assessment.*

- **Screener:** Leader generated risk assessment.
- **Enablers:** ABHC, Operational Medical Assets
- **Mode:** Down-Range Assessment Tool (D-RAT)
- **Outcome:** Identify at-risk Soldiers and communicate to Reverse SRP site to assist reintegration. Stratifies risk.
- **Target:** Soldiers (legal, financial, disciplinary, relational, resilience, and behavioral health).
- **Proposed:** Expanded Family risk assessment.

TOUCH POINT #5

Periodic Health Assessment Screening: *Annual screening and intervention.*

- **Screener:** Primary Care and Behavioral Health provider. NDAA 2010 requires face to face provider screening.
- **Enablers:** ABHC, RESPECT.Mil, Face to Face
- **Mode:** Electronic Medical Record **(**EMR)
- **Outcome:** Identifies residual risk and delayed onset of behavioral health and medical issues. Stratifies risk.
- **Target:** Medical and behavioral health for Soldiers.
- **Proposed:** Medical and behavioral health for Family.



TOUCH POINT #3

Reintegration PDHA: *6-30 days (before block leave) redeployment screening for risk assessment with additional BH assessment and wellness intervention.*

- **Screener:** Primary Care and Behavioral Health Provider. NDAA 2010 requires face to face provider screening.
- **Enablers:** ABHC, VBH, face to face
- **Mode:** DD FORM 2796 + SAT I / SAT II
- **Outcome:** Immediate intervention for high risk Soldiers, support to Soldiers as indicated. Stratifies risk.
- **Target:** Medical and behavioral health for Soldiers.
- **Proposed:** Medical and behavioral health for Family.

TOUCH POINT #4

Reintegration PDHRA: *90-180 days re-deployment screening and intervention for risk assessment with additional BH assessment and wellness intervention.*

- **Screener:** Primary Care, given at SRP, provider reviewed and referrals given when indicated. NDAA 2010 requires face to face provider screening.
- **Enablers:** ABHC, VBH, face to face
- **Mode:** DD Form 2900 + SAT I / SAT II
- **Outcome:** Identifies residual risk and delayed onset of behavioral health and medical issues. Stratifies risk.
- **Target:** Medical and behavioral health for Soldiers.
- **Proposed:** Medical and behavioral health for Family.